Division of Licensing and Protection
103 South Main Street
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

October 16, 2015

Ms. Devida Deluca, Manager
Living Well Residence
1200 North Avenue
Burlington, VT 05408-1004

Dear Ms. Deluca:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 24, 2015.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PRINTED: 09/02/2015
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0543	A. BUILDING: _____ B. WING _____	C 08/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING WELL RESIDENCE	71 MAPLE STREET BRISTOL, VT 05443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced on-site complaint investigation was conducted by the Division of Licensing and Protection on 8/24/15 and resulted in identification of the following regulatory violations.	R100		
R126 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.a Upon a resident's admission to a residential care home, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the home failed to provide appropriate supervision to meet the personal and psychosocial care needs of 1 of 3 applicable residents. (Resident #1). Findings include: Per record review Resident #1's most recent assessment, dated 1/5/15, reflected a deterioration in his/her status, both physically and cognitively, indicating that the resident's cognitive ability for decision making was severely impaired. A care plan, dated 5/4/15, identified a risk for harm due to cognitive impairment related to wandering and confusion and cited a goal of safe activities without injury. The plan of action included: permit to be active and ambulate within safe region/parameters; monitor activities closely ...allow for ambulation short distances outside, with supervision - two block radius and return	R126	see attached	

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATE FORM 6899 FEKF11 If continuation sheet 1 of 6

Jeanette O'Conor PA-C/MSPAS September 15, 2015

R126 - R188 POC's accepted as encircled on attached pages 10/15/15 PMcotaRN

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R126	Continued From page 1	R126		

within 20 minutes. Progress notes from May through July 2015 indicated that the resident usually informed staff of when s/he was leaving for a walk. A progress note, dated 8/10/15, indicated that sometime on the late afternoon of 8/7/15, the resident had told staff that s/he was going to take a walk and, although the note did not indicate the time the resident left, s/he was returned to the home around 7 PM by a community member who found the resident wandering down a steep hill approximately 1 mile from the home, and well outside the previously determined 2 block radius. The note further indicated that the community member had reported the resident was limping and exhibited confusion in that s/he did not know where s/he was or how to get home. Another note, dated 8/13/15, indicated that the resident had reportedly gone to sit outside the house at approximately 8:15 PM that evening and subsequently wandered off, without staff knowledge. Staff became concerned at approximately 8:45 PM when it became dark and they could not locate the resident. Upon searching, the resident was again found wandering, outside the 2 block radius, down the steep hill approximately a mile from the home. Despite this recent behavior change in wandering outside of the established walking parameter, as well as the wandering away from the home without staff knowledge, there was no evidence to suggest that staff were monitoring/supervising the resident's activities on a more frequent basis and subsequently, Resident #1 again exited from the home on the evening of 8/22/15 and was found by a community member at the bottom of the same steep hill, confused and refusing, for a time, to go back to the home.

During interview, on the afternoon of 8/24/15, the

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R126	Continued From page 2 home's Administrator and DNS (Director of Nursing Services) both acknowledged that Resident #1 had recently, on 3 separate occasions, wandered outside the established two block area of the village and down a steep hill, without staff knowledge. The DNS agreed that the resident's recent behavior indicated a need for closer supervision by staff.	R126		
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the care plan, for one of three applicable residents, had not been revised to reflect the resident's current status and care and services necessary to assist him/her to safely maintain their independence and well-being. (Resident #1). Findings include: Per record review Resident #1 was admitted to the home in February 2013 with medical conditions that included dementia. The most current resident assessment, completed on 1/5/15, reflected a deterioration in the resident's status, both physically and cognitively, indicating that the resident's cognitive ability for decision making was severely impaired. A care plan, dated	R145	see attached	

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R145	Continued From page 3	R145		

5/4/15, identified a risk for harm due to cognitive impairment related to wandering and confusion, and cited a goal of safe activities without injury. The plan of action included: permit to be active and ambulate within safe region/parameters; monitor activities closely ....allow for ambulation short distances outside, with supervision - two block radius and return within 20 minutes. Progress notes from May through July 2015 indicated that the resident usually informed staff of when s/he was leaving for a walk. A progress note, dated 8/10/15, indicated that sometime on the late afternoon of 8/7/15, the resident had told staff that s/he was going to take a walk and, although the note did not indicate the time the resident left, s/he was returned to the home around 7 PM by a community member who found the resident wandering down a steep hill approximately 1 mile from the home, and well outside the previously determined 2 block radius. The note further indicated that the community member had reported the resident was limping and exhibited confusion in that s/he did not know where s/he was or how to get home. Another note, dated 8/13/15, indicated that the resident had reportedly gone to sit outside the house at approximately 8:15 PM that evening and subsequently wandered off, without staff knowledge. Staff became concerned at approximately 8:45 PM when it became dark and they could not locate the resident. Upon searching, the resident was again found, wandering, outside the 2 block radius, down the steep hill approximately a mile from the home. Despite this recent behavior change in wandering outside of the established walking parameter, as well as the wandering away from the home without staff knowledge, the care plan was not revised to reflect an obvious need for closer supervision. Subsequently, and although an

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R145	Continued From page 4 incident report, dated 8/22/15, revealed that Resident #1 had, again, eloped from the home that evening and was found by a community member at the bottom of the same steep hill, confused and refusing, for a time, to go back to the home, the care plan had still not been revised to reflect a need for closer supervision of the resident in a manner that would help assure his/her safety while maintaining a sense of independence and well-being. During interview, on the afternoon of 8/24/15, the home's Administrator and DNS (Director of Nursing Services) both acknowledged that Resident #1 had recently, on 3 separate occasions, wandered outside the established two block area of the village and down a steep hill, without staff knowledge. The DNS agreed that the resident's recent behavior reflected a need for closer supervision and confirmed that, despite this recent change in behavior the resident's care plan had not been revised to reflect that need.	R145		
R188 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(2) A record for each resident which includes: resident's name; emergency notification numbers; name, address and telephone number of any legal representative or, if there is none, the next of kin; physician's name, address and telephone number; instructions in case of resident's death; the resident's assessment(s); progress notes regarding any accident or incident and subsequent follow-up; list of allergies; a signed admission agreement; a recent photograph of the resident, unless the resident	R188	see attached	

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R188	Continued From page 5 objects; a copy of the resident's advance directives, if any completed; and a copy of the document giving legal authority to another, if any. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the record for 1 of 3 applicable residents did not include a progress note related to an incident in which the resident exited from the home without staff knowledge. (Resident #1). Findings include: Per record review Resident #1, who had a care plan with established parameters for unescorted walks within a 2 block radius of the home, was found wandering well outside those parameters without staff knowledge, on 3 separate occasions between 8/7/2015 and 8/22/15. Although the incidents that occurred on 8/7/15 and 8/13/15 were reflected in progress notes in the resident's record, there was no documentation in his/her record of the incident that occurred on the evening of 8/22/15 in which the resident was found wandering down a steep hill approximately 1 mile from the home. During interview, on the afternoon of 8/24/15, the DNS (Director of Nursing Services) confirmed the lack of documentation of the incident in the resident's record.	R188		

Living Well Residence, Bristol Vermont

Plan of Correction: Survey dated 8/24/2015

Corrections:

V. 5.5 a General Care: Regarding personal, psychosocial, nursing and medical care needs unmet:

The following actions were taken and implemented into resident care: Effective immediately (8/24/2015)

- Thorough review of resident's plan of care and negotiated risk agreement were conducted on the day of the survey (8/24/2015). Discussion ensued with resident's son/DPOA to review his wishes which were outlined in specific detail in the current negotiated risk agreement. During this discussion our team review with son/DPOA his wishes for his mother to have freedom to walk outside of the building. Our discussions then addressed whether staff responses to his mother's walking were in alignment with his wishes outlined in the negotiated risk agreement. Based upon this conversation, we mutually agreed that our response to her walking independently in Bristol was consistent with what was outlined and agreed upon in the negotiated risk agreement.
- Resident's care plan was reviewed to address the safety goals outlined by state surveyor, although these factors were addressed in the resident's negotiated risk agreement. The resident's care plan was updated in consultation with son/DPOA to outline safety goals while the resident is walking outside of the building. The revised care plan states that should the resident leave the building for a walk, she will have supervision for her walk.
- Resident's negotiated risk agreement was revised with her son/DPOA and updated to outline his wishes in light of the resident's current condition. He continues to wish for her to have as much independence in walking as possible while observing her safety.
- Safety guidelines for residents who require supervision walking outdoors were written and reviewed with care giving staff. The guidelines address steps to follow for residents walking safely outdoors; this serves in conjunction with our elopement guidelines for residents.
- Marshall's Security Service in Middlebury VT has been contacted and will be placing an alarm system on the primary doors of the residence building to notify staff when a resident leaves the building unattended. Expected date of completion and installation: November 1, 2015.

Systemic changes made to ensure deficient practices do not recur: Effective immediately (8/27/2015)

- Implementation of new safety guidelines for residents who require supervision walking outdoors in addition to our elopement guidelines were written and reviewed with all staff at two of the most recent staff meetings (8/27/2015, 9/3/2015). This addresses safety issues so that any resident who is deemed needing supervision, will be attended to and observed while walking outdoors.
- The Living Well Residence Director of Nursing will seek clarification and guidance from the state regulatory body DLP regarding understanding, regulation and implementation of "negotiated risk agreements" for residents in residential care settings.

Plans of correction accepted as encircled. PMcetaPN

How Practices Are Being Monitored to Prevent Recurrence: Effective immediately (9/1/2015) and ongoing

- On a monthly basis at the residential care staff meeting, resident status is reviewed. At that time all residents requiring supervisory care outside of the building will have their plans of care reviewed with staff to ensure that the safety guidelines are being followed.
- Any resident elopement will be reviewed at the time of elopement event, to identify whether the process broke down, and to immediately implement improvement at that time.
- Quarterly review of incident reports will be conducted with the residence manager, and the director of nursing to track whether the safety guidelines are being implemented effectively.

V. 5.9b Resident Care and Home Services: Plan of Care

V. 5.12c Resident Care and Home Services: Progress Note

The following actions were taken and implemented into resident care: Effective immediately (9/3/2015)

- Care plan for the resident in question was updated on the date of the survey to reflect the changes in supervision required for walking safely outside the building.
- Progress note for the resident in question on her event that occurred two days prior to surveyor visit was documented in the nursing notes as a late entry.

Systemic changes made to ensure deficient practices do not recur: Effective immediately (9/3/2015)

- Resident status are reviewed monthly during the staff meetings and any updates or changes to care plans will be made at that time; and/or amended at any other time changes are noted.
- Staff were given education and training at the most recent staff meeting (9/3/2015) on proper documentation of resident events.

How Practices Are Being Monitored to Prevent Recurrence: Effective immediately (9/3/2015) and ongoing

- Nursing Director and Staff Manager for the Residence will implement process of weekly auditing of documentation to ensure its accuracy and completion (effective 9/21/2015). Weekly auditing will be conducted by the night shift on Sunday nights for the full week prior. The night shift will complete the auditing form-which will be left for the staff manager that Monday morning, for review and follow up.

* Licensing Agency note: There is no provision for "negotiated risk agreements" in the Residential Care Home regulations. PMcotaRN